North Carolina Department of Health and Human Services
Division of Medical Assistance - Provider Services
2501 Mail Service Center - Raleigh NC 27699-2501
Telephone (919) 855-4050
http://www.dhhs.state.nc.us/dma/

RESIDENTIAL CHILDCARE FACILITY (Level II, III and IV) RE-ENROLLMENT ADDENDUM INSTRUCTIONS

Dear Residential Childcare Provider,

Thank you for your interest in re-enrolling as a Residential Childcare Facility Level II, III or IV provider with the NC Medicaid Program. Residential providers' site-specific Medicaid provider numbers are scheduled to end date on the expiration date of your endorsement or license, whichever date is earlier. **To renew your Medicaid enrollment, you must submit the following to DMA prior to the end date of your Medicaid provider number:**

1. **A completed Residential Childcare Facility (Level II, III and IV) Re-enrollment Addendum.** The original Addendum with original signature and required attachments must be submitted together. Incomplete Addendum packets will be returned to the provider by mail for completion. **Please staple each packet to secure all of the pages and documents together**. Faxes will not be accepted. Correction fluid, highlighter, strikethroughs and any alterations to the addendum are not acceptable.
   The provider name on the addendum must match exactly the provider name on your original Medicaid Participation Agreement.
   Write your Medicaid provider number in the upper right corner of each page of the Addendum and each attached document.

2. **A copy of your Notification of Endorsement Action (NEA) letter issued by your Local Management Entity (LME).** The NEA letter must reference the name of the facility and the physical address of the facility as reflected on your facility license. You must write your Medicaid provider number in the upper right corner of the NEA. *In addition to this annual re-enrollment, each time you are issued a renewed NEA from your Local Management Entity (LME), you must submit a copy of that renewed NEA (with your Medicaid number written on it) to DMA to ensure continuous Medicaid enrollment.*

3. **A copy of your renewed facility license issued by The Division of Health Service Regulation (DHSR), formerly known as The Division of Facility Services (DFS).** You must write your Medicaid provider number in the upper right corner of the license.

4. **If you desire to receive acknowledgement that your documents have been received at DMA**, you must complete the attached acknowledgement card and submit it with your addendum packet. It will be helpful if you submit your packet with this page on top.

MAIL THE ADDENDUM PACKET TO:
DMA Provider Services - 06
Attn: Residential Childcare
2501 Mail Services Center
Raleigh, NC 27699-2501

You will be notified by mail once your addendum packet has been approved and your Medicaid participation has been renewed. Please do not submit claims for any services until you have received notification of the renewal of your provider number. Billing information and medical coverage polices are available on DMA's website at http://www.dhhs.state.nc.us/dma/prov.htm. Thank you again for your interest, if you have any questions or need additional information, please feel free to contact your Residential Services Provider Enrollment Specialist at (919) 855-4070.

INSTRUCTIONS FOR APPLICATION ACKNOWLEDGEMENT CARD

Please fill in the information below.
This is our method of acknowledging receipt of your application.

PLACE A STAMP ON THE ACKNOWLEDGEMENT CARD TO ENSURE DELIVERY BY THE POST OFFICE.

Provider Services
DHHS/DMA
2501 Mail Services Center
Raleigh NC 27699-2501

PLACE STAMP HERE. POST OFFICE WILL NOT DELIVER WITHOUT PROPER POSTAGE.

_____
Name

_____
Address

_____
City State Zip Code

APPLICATION ACKNOWLEDGEMENT CARD

Dear Prospective Provider:

We have received your application for enrollment in the NC Medicaid Program.

DMA will notify you of your status via mail once the enrollment process has been completed, or in the event additional information is needed.

Thank you again for your interest in the NC Medicaid Program.

Sincerely,

DMA Provider Services

Medicaid Provider # _____

North Carolina Department of Health and Human Services
Division of Medical Assistance
Provider Services

RESIDENTIAL CHILDCARE FACILITY (Level II, III or IV) REENROLLMENT ADDENDUM

ALL FIELDS ARE REQUIRED. INCOMPLETE ADDENDUMS WILL BE RETURNED TO THE PROVIDER, WHICH MAY RESULT IN DELAYED RENEWAL AND DENIED CLAIMS

Type or Print (legibly) All Information in Black Ink

1. Type of Service: (check only one)
   - ❒ Level II HRI – Residential Treatment 27G.1300 license
   - ❒ Level III HRI – Residential Treatment 27G.1700 license
   - ❒ Level IV HRI – Residential Treatment 27G.1800 license

2. Medicaid Provider Number: _____ 3. NPI Number: _____

4. Name of Facility: _____
(as reflected on license and must match the name on original Medicaid Participation Agreement)

5. Facility Physical Address: _____
(Street Address as reflected on license)

_____
City State Zip code **+ 4 digits**

_____ 6. Mental Health License Number: MHL-_____-_____.
County (as reflected on license)

7. Mailing/Payment Address: _____

_____
City State Zip code **+ 4 digits**

8. Telephone Number: ( ) _____ - _____ Extension _____

9. Fax Number: ( ) _____ - _____

10. E-mail Address: _____

11. Fiscal Year End Date: _____
(Month and Day that your financial year ends)

12. Contact Person's Name: _____

13. Contact Person's Telephone Number: ( ) _____ - _____

Continued on next page

Medicaid Provider # _______________

RESIDENTIAL CHILDCARE FACILITY (Level II, III or IV) REENROLLMENT ADDENDUM

14. List all shareholders/partners **(including yourself)** who have **5% or more ownership interest** AND all individual officers, directors, managers, and Electronic Funds Transfer (EFT) authorized individuals and information requested on each. In addition, Non-Profits should complete the fields below to identify the Board of Directors. Use an additional page if necessary. ***All questions must be answered. Failure to provide true and correct information, or providing information that is false or misleading shall be cause for denial or termination of participation as a Medicaid Provider. Federal law requires disclosure of the Social Security Number. DMA protects this information in accordance with privacy and confidentiality law.***

Name and Address	Title	SSN	% Owner
	Relationship to enrolling provider:		
	❑ Owner ❑ Shareholder ❑ Partner ❑ Board Member		
	❑ Spouse ❑ Parent ❑ Child ❑ Sibling ❑ Other		

Name and Address	Title	SSN	% Owner
	Relationship to enrolling provider:		
	❑ Owner ❑ Shareholder ❑ Partner ❑ Board Member		
	❑ Spouse ❑ Parent ❑ Child ❑ Sibling ❑ Other		

Name and Address	Title	SSN	% Owner
	Relationship to enrolling provider:		
	❑ Owner ❑ Shareholder ❑ Partner ❑ Board Member		
	❑ Spouse ❑ Parent ❑ Child ❑ Sibling ❑ Other		

Name and Address	Title	SSN	% Owner
	Relationship to enrolling provider:		
	❑ Owner ❑ Shareholder ❑ Partner ❑ Board Member		
	❑ Spouse ❑ Parent ❑ Child ❑ Sibling ❑ Other		

15. Have you, or individuals or organizations having a direct or indirect ownership or controlling interest of five percent (5%) or more in this business been convicted of a criminal offense related to the involvement of such persons or organization in the programs of Medicaid (Title XIX) or Social Services Block Grant (XX)?
Yes ❑ **No ❑** **(If you answered 'Yes', attach explanation)**

16. Have any of your directors, officers, agents or managing employees of your group been convicted of a criminal offense related to their involvement in the program of Medicaid, Medicare or Social Services Block Grant?
Yes ❑ **No ❑** **(If you answered 'Yes', attach explanation)**

17. Have civil monetary penalties <u>ever</u> been levied against this corporation, business, agency or facility by Medicare, Medicaid or other State or Federal Agency or Program?
Yes ❑ **No ❑** **(If you answered 'Yes', attach explanation)**

Continued on next page

RESIDENTIAL CHILDCARE FACILITY (Level II, III or IV) REENROLLMENT ADDENDUM

18. Have civil monetary penalties ever been levied by Medicare, Medicaid or other State or Federal Agency or Program against any other corporation, business, agency or facility in which shareholders/partners listed in Item '14' on page two of this Addendum had 5% or more ownership interest including yourself, individual officers, directors or managers?
Yes ❑ No ❑ (If you answered 'Yes', attach explanation)

19. Have you or <u>any of the individuals listed in Item '14' on page two of this Addendum ever</u>:

a. Been convicted of a felony, had adjudication withheld on a felony, pled no contest to a felony or entered into a pre-trial agreement for a felony?
Yes ❑ No ❑
If yes, list the name(s) of the individual(s) and provide a copy of the administrative complaint and final disposition:

_____

_____

b. Had any disciplinary action taken against any business or professional license held in this or any other state? Or had your license to practice restricted, reduced or revoked in this or any other state?
Yes ❑ No ❑
If 'Yes' to 'E b', complete below and attach a copy of the final disposition. Attach documentation from the proper authorities that approve the reinstatement of the license:

Against Whom?	Action Taken?	Who took Action?	Date of Action?

c. Been denied enrollment, been suspended or excluded from Medicare or Medicaid in <u>any state</u>, or been employed by a corporation, business, or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state?
Yes ❑ No ❑
If 'Yes', list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation:

Name	Medicaid Provider Number

d. Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that had suspended payments from Medicare or Medicaid in any state?
Yes ❑ No ❑

e. Owes money to Medicaid or Medicare that has not been paid?
Yes ❑ No ❑ (If you answered 'Yes', attach explanation)

Continued on next page

Medicaid Provider # _____

RESIDENTIAL SERVICES (Level II, III or IV) REENROLLMENT ADDENDUM

20. Is the organization, agency or business incorporated?

Yes ❑ No ❑

If yes, please attach a copy of the completed Application for Incorporation, complete copy of Certified Articles of Incorporation and complete copy of any subsequent changes to the Application/Articles of Incorporation.

21. **Signature of Owner(s) or Authorized Agent Required:**

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider.

_____ _____

Signature of Owner or Authorized Agent **Date**

_____

Printed Name and Title of person signing above

** Providers, do not write below this space **

FOR INTERNAL USE BY THE DIVISION OF MEDICAL ASSISTANCE

EFFECTIVE DATE:

This agreement is executed and shall become effective on the _____ day of _____ in the year of _____.

The agreement shall remain subject to renewal on a periodic basis. A new agreement may be required as DMA necessitates, by operation of law, Medicaid regulations, polices or other material circumstances, or termination upon substitution of a new agreement, or by act of the parties as herein provided. You are herein authorized to provide services which are in accordance with the approved service definitions.

DMA APPROVAL:

Accepted on _____ by _____